

16245

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUN 4 1943 318

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4832

1. PLACE OF DEATH:

(a) County: .....  
(b) City or town: St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 7 Hrs. 10 Min  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: Junior Phelps Jackson

3. (b) If veteran, name war: ..... 3. (c) Social Security No. ....

4. Sex: Male 5. Color or race: Negro 6. (a) Single, widowed, married, divorced: 0  
6. (b) Name of husband or wife: ..... 6. (c) Age of husband or wife if alive: ..... years  
7. Birth date of deceased: 4 29 43  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
NB 7 hr. 10 min.

9. Birthplace: St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: .....

11. Industry or business: .....

MOTHER, FATHER { 12. Name: .....  
13. Birthplace: .....  
14. Maiden name: Circe Jackson  
15. Birthplace: Newport Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant: Edith M. Sherrard R.R.D.

(b) Address: 2601 N. Whittier Street

17. (a) Burial (b) Date thereof: MAY 27 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CITY CEMETERY

18. (a) Signature of funeral director: J. F. Brudeak

(b) Address: 2601 N. Whittier Street

19. (a) MAY 26 1943 (b) J. F. Brudeak  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: .....  
(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No.: 930 N. Sarah Street  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country: .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 29  
year 43 hour 5 minute 40 p. M.

21. I hereby certify that I attended the deceased from 4  
29, 19 43 to 4-29, 19 43,  
that I last saw him alive on 4-29, 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity Duration: .....

Due to: Unknown

Due to: Unknown

Other conditions: .....  
(Include pregnancy within 3 months of death)

Major findings: Of operations: .....

Of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): .....

(b) Date of occurrence: .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? ..... (Specify type of place) (e) Means of injury: .....

23. Signature: E. H. Dickson (M. D. or other) 5-28-43

Address: 2601 N. Whittier Street Date signed: .....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**